STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING B. WING (X3) DATE SURVE  COMPLETED  02/23/2012				ETED	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	Complaints INO Complaint INOO Federal/State de allegation are ci Complaint INOO Federal/State de allegation are ci Survey date: Fel Facility number Provider numbe AIM number: 20 Survey team: Sandra Haws RI	0104251 Substantiated. eficiencies related to the ted at F203 bruary 23, 2012 : 012329 er: 155784 01002500	F00	00			
	Census bed type	<b>:</b> :					
	SNF: 30						
	SNF/NF: 46						
	Total: 76						
	Census payor ty Medicare: 31 Medicaid: 27 Other: 18 Total: 76	rpe:					
	Sample: 3						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

35GV11

PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIES X1) PROVIDER/SUPPLIER	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI <b>02/23</b>	ETED
	ROVIDER OR SUPPLIER  A HEALTH AND REHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.				
	Quality review completed 2/28/12 Cathy Emswiller RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet

Page 2 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155784	B. WIN	G		02/23/2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					DOUGLAS RD	
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER		MISHAV	NAKA, IN 46545	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0203 SS=E	483.12(a)(4)-(6) NOTICE REQUII TRANSFER/DIS Before a facility tresident, the facility tresident, the facility tresident, the facility tresident, the facility and, if known, a representative of or discharge and writing and in a launderstand; recording the items of this section.  Except when specific this section, the discharge required this section must least 30 days be transferred or dischargered or dischargered und the resident's he allow a more immedischarge, under section; an immerequired by the rededs, under particular to the section of the resident of the rededs, under particular treatment of the rededs of the reded of the rededs of the reded of the re	transfers or discharges a lity must notify the resident family member or legal if the resident of the transfer If the resident of the transfer If the reasons for the move in anguage and manner they ord the reasons in the If record; and include in the described in paragraph (a)(5)(ii) are notice of transfer or red under paragraph (a)(4) of the made by the facility at fore the resident is scharged.  In add as soon as practicable or discharge when the health the facility would be refer (a)(2)(iv) of this section; alth improves sufficiently to mediate transfer or paragraph (a)(2)(i) of this regiant (a)(2)(ii) of this regiant (a)(2)(iii) of this regiant (a)(2)(iii) of this regraph (a)(2)(iii) of this regraph (a)(2)(iii) of this		TAG	DEFICIENCY)	DATE
	facility for 30 day	dent has not resided in the vs.				
	(4) of this section transfer or dischatransfer or dischate the resident is transfer that the statement that the appeal the action	e specified in paragraph (a) n must include the reason for arge; the effective date of arge; the location to which ansferred or discharged; a ne resident has the right to n to the State; the name, uphone number of the State				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet Page 3 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPL	
155784			B. WIN	_		02/23/	2012
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP CODE		
MICHIAN	NA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD WAKA, IN 46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC			(X5)
					CROSS-REFERENCED TO THE APPROPRIA	ATE.	
PREFIX TAG	long term care of facility residents disabilities, the relephone number for the protection developmentally established undopevelopmental Bill of Rights Actresidents who an address and tele responsible for to facility failed responsible for to facility failed related to Notice was available in discharge to ensurance of his or bresidents discharge to ensurance of his or bresidents discharge to facility failed related to Notice was available in discharge to ensurance of his or bresidents discharge to facility failed to the facility failed related to Notice was available in discharge to ensurance of his or bresidents discharge to facility failed facility failed to his or bresidents discharge to facility failed fa	Disabilities Assistance and t; and for nursing facility are mentally ill, the mailing ephone number of the agency he protection and advocacy dividuals established under and Advocacy for Mentally Ill ews and record review, at to ensure documentation to of Transfer or Discharge the resident's record after are the resident was made are appeal rights for 3 of 3 arged from the facility in a tesidents # B, #C, and #	F02	PREFIX TAG	F203 It is the practice of this facility to provide the reside with written notice of their ri to appeal discharge to the State; the name address and telephone number of the Stal long term care ombudsman.  CORRECTIVE ACTION: Resident B, C, and D were provided the transfer/discharge with appeal information upon discharge from the facility. Supportive documentation is ravailable. HOW OTHERS IDENTIFIED: All residents be discharged or transported out facility are at risk. PREVENTATIVE  MEASURES: Sticker with the following information has been added to the Social Service Discharge Summary. "Notice Transfer or Discharge Request following Facility Bed Hold Policy given on "With	nt ght I te	O2/27/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet Page 4 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
155784			B. WIN			02/23/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			WAKA, IN 46545		
			_		,		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	NI.
TAG	`	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	JIN
TAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		TAG	place for resident signature. A		
					sticker with the following	·	
	The resident's re	cord indicated he was			information was added to the		
	discharged from	the facility on 2/15/12.			Resident Transfer Form. "A co	yaq	
	The record lacke	ed information to indicate			of the Notice of Transfer or		
	the resident was	given a Notice of			Discharge, Notice of Transfer	or	
		harge, or notification of			Discharge Request for Hearin	g,	
	his appeal rights	<b>O</b> ,			and nursing Bed Hold Policy v	vere	
	ins appearingitts	-			sent with this resident on		
					(nurse		
		interview with APS			signature)	Bot	
	(Adult Protective	e Services) # 4 on 2/23/12			h of these will ensure that	DUI	
	at 12:40 p.m. she	e indicated she had gone			supportive documentation is		
	to see the resider	nt at his home when he			available to ensure that the		
	returned from th	e facility. She indicated			information was sent with		
		t his discharge papers			residents upon discharge fron	ı	
		er she could find was a			facility. <b>MONITORING:</b> DON		
					and/or designee will monitor t		
	notice of lack of	payment.			charts of residents that go out		
					appointments or residents that	t	
	During an interv	iew with the			are discharged from facility to ensure that the		
	Administrator or	n 2/23/12 at 2:00 p.m. she			transfer/discharge/appeal		
	indicated the fac	ility did not offer the			information has been provided	, l	
	resident an invol	untary discharge notice			Findings will be addressed		
		oluntarily. She further			through the facilities monthly	QPI	
		yould not be any Notice			process. Any deficient practic		
		•			noted will be addressed throu	gh	
		ischarge in his record			education, in-service and/or		
		ent with him at the time			disciplinary action.		
	of discharge.				ADDENDUM:		
					DON and/or designee will monitor the charts of resider	nte	
	During a continu	ed interview with the			going out for appointments		
	Administrator re	garding discharge			who are discharged home da		
	documentation,				for 2 weeks, then 3 times pe	- I	
	·	vrites the order to			week for 4 weeks, then week		
	1 ^ -	arse only writes the			for 16 weeks, then monthly f	_	
					2 months.		
		ctions out and Social					
	Service fills out	his discharge form.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet

Page 5 of 9

PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPL <b>02/23</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER				1420 E [	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN 46545	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
		ntioned regarding the otified of his or her appeal					
	5 on 2/23/12 at 2 transfer or discha indicated he mak	iew with Social Service # :20 p.m. regarding arge documentation, he tes a note in the record the uses when a resident is					
	"Social Service I dated 2/15/12 3:15 following inform name, where the mode of transpormade, notification receiving agency (equipment, order interdisciplinary up (contact personadditional common where on the form record was information resident was given Transfer Dischart	ial Service form titled Discharge Summary" 30 p.m. indicated the nation; The resident's person is discharged to, rtation, any referrals on (resident, family, r), discharge information ers from physician, team aware) and follow on). The area for ents was blank. No m or in the resident's mation to indicate the en the information for try instruction or appeal to this discharge at that					
	on 2/23/12 at 2:0 record indicated	's record was reviewed 5 p.m. The resident's diagnoses of, but not deficiency anemia,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet

Page 6 of 9

PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155784		(X2) MUI A. BUILE B. WING		00	(X3) DATE : COMPL 02/23/	ETED	
NAME OF PROVIDER OR SUPPLIER  MICHIANA HEALTH AND REHABILITATION CENTER				1420 E [	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤЕ	(X5) COMPLETION DATE
	The residents Ad (Minimum Data /12 indicated the intact.  Review of Social Summary dated 2 indicated the foll resident's name, discharged to, many referrals made family, receiving information (equiphysician, interdiguant follow up (considered for additional considered was information to the formation of the for	Set) assessment dated 2 resident's cognition was  I Service Discharge 2/21/12, 2:00 p.m. owing information; The where the person is ode of transportation, de, notification (resident, gagency), discharge ipment, orders from isciplinary team aware) ontact person). The area mments was blank. No m or in the resident's mation to indicate the en the information for er or Discharge or appeal gher discharge at that  cord indicated she was the facility to home on ord lacked information to lent was made aware of by having egarding a Transfer being given to the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet

Page 7 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
155784			B. WING			02/23/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER		MISHAV	VAKA, IN 46545		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s record was reviewed on					
	_ ^	o.m. The resident's record					
	_	ses of, but not limited to;					
	Morbid obesity,						
	_	he resident's record					
	indicated she wa	s discharged from the					
	facility on 1/18/1	12.					
		l Service Discharge					
	Summary dated	1/20/12, 4:00 p.m.					
	indicated the foll	lowing information; The					
	resident's name,	where the person is					
	discharged to, m	ode of transportation,					
	any referrals mad	de, notification (resident,					
	family, receiving	g agency), discharge					
	information (equ	ipment, orders from					
	` *	isciplinary team aware)					
	1 * *	ontact person). The area					
		mments was blank. No					
		m or in the resident's					
		mation to indicate the					
		en the information for					
	Notice of Transf						
		peal rights concerning her					
	discharge at that						
	arsonarge at that	viiii.					
	The record lacke	ed information to indicate					
		made aware of her appeal					
		documentation regarding					
	1	sfer or Discharge being					
		dent at time of discharge.					
	given to the resid	ioni ai inne oi discharge.					
	During an interv	iew with the Director of					
	_	/12 at 5:30 p.m. regarding					
	Truising on 2/23/	12 at 3.30 p.m. regarding					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet Page 8 of 9

PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMF	ESURVEY	
		155784	B. WING			3/2012
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP ( DOUGLAS RD NAKA, IN 46545	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	rights for dischart "You won't find resident's chart."	rge notices and appeal rged residents, she stated one on any discharged relates to Complaints #				
	IN00104133 and	_				
	3.1-12(a)(5)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35GV11

Facility ID: 012329

If continuation sheet

Page 9 of 9